Cleveland Clinic Florida
Registration / Appointment Request Form
Submit via Email: gonzalm2@ccf.org or Fax: 954-659-5649

Date: _____/_____/_____

Last Name: _____ **First Name:** _____

Address: _____

City: _____ **State:** _____ **Zip code:** _____

Home: _____ **Work:** _____

Cell: _____ **Fax:** _____

Date of Birth: _____ **Sex (circle):** *Male* *Female*

Marital Status: _____ **Ethnicity:** _____ **Race:** _____

Language Spoken: _____ **Visually Impaired:** *Yes* *No* **Deaf:** *Yes* *No*

Reason for Visit/Chief Complaint/Diagnosis: _____

_____

Sport Related (circle): *Yes* *No*

Email: _____

Emergency contact: _____ **Phone:** _____

Insurance Name: _____

Insurance Address: _____

Member ID#: _____ **Group #:** _____

Policy Effective Date: _____

Employer Name _____

Position/Title: _____

Employer Address: _____

Employer Phone number: _____

Any questions, please contact Jackie Gonzalez at 954-659-6175